

Ticket #: _____ Request Date: _____ Request Time: _____

PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of Trokendi® topiramate ER. Based on recent clinical information, we require more information before this prescription can be paid by the patient's health benefit plan. Please fill out the following information and return to us as indicated below:

A. Member Information			
Patient Name:		Plan Name/Plan ID:	
Patient ID:		Patient Date of Birth:	Patient Contact Phone #:
B. Physician Information			
Physician Name:		Physician Address:	
Physician DEA #:	Physician Phone #:	Physician Fax #:	
Drug Name and Strength:	Direction (SIG):	QTY and Days Supply:	NDC #:
C. Pharmacy Information			
Pharmacy Name:	NABP #:	Pharmacy Phone #:	Pharmacy Fax #:
D. Clinical Information (Please fill out the following information: circle all that apply)			
1. Is the patient over the age of 18?		YES	NO
2. Does the patient have confirmed diagnosis of: (please provide documentation)			
<input type="checkbox"/> Partial Onset Seizure			
<input type="checkbox"/> Primary generalized tonic-clonic seizures			
<input type="checkbox"/> Lennox-gastatut syndrome (LGS) from a neurology specialist			
3. Has the patient tried generic topiramate?		YES	NO
Authorized Medical Signature:			
Telephone:		Date:	

When Completed Return To:

ProCare PBM Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736